Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Level A & B Acute Physical Medicine & Rehabilitation (Acute PM&R)

Inpatient Hospitals and Nursing Facilities Billing Instructions

(Chapter 388-550 WAC)

September 1999

About this publication

This publication supersedes all previous MAA Level A & B Acute Physical Medicine & Rehabilitation (Acute PM&R) Inpatient Hospitals and Nursing Facilities Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
September 1999

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Table of Contents (cont.)

Important Contacts

How do I apply for a provider number?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	(360) 664-0300
I-O	(360) 753-4712
P-Z	(360) 753-4711

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9246
Olympia WA 98507-9246

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Unit
1-800-562-6188

Prior Authorization?

Division of Health Services Quality Support
Clinical Consultation Team
1-800-634-1398

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45564
Olympia, WA 98504-5564
(360) 753-0318

This is a blank page…

Definitions

This section defines terms and acronyms used in these billing instructions.

Accredit (or Accreditation) – A term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care. (WAC 388-550-2511)

Acute – An intense medical episode, not longer than two months. (WAC 388-550 2511)

Acute PM&R - A comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement. (WAC 388-550 2511)

Authorization - Official approval for department action.

Authorization Number - A nine-digit number assigned by MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied. (WAC 388-550-1050)

Authorization Requirement - MAA's requirement that a provider present proof of medical necessity to MAA, prior to providing certain medical services or equipment to a client. This takes the form of a request for authorization of the service(s) and/or equipment, including a complete, detailed description of the client's diagnosis and/or any disabling conditions, justifying the need for the equipment or level of service being requested. (WAC 388-550-1050)

CARF – The official name for "The Rehabilitation Accreditation Commission" of Tucson, Arizona. CARF is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and accreditations of rehabilitation facilities. (WAC 388-550-2511)

Categorically Needy Program (CNP) – Federally-matched Medicaid program that provides the broadest scope of medical coverage. Persons may be eligible for CNP only or may be eligible for cash benefits under the Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF) programs. Includes full scope of coverage for pregnant women and children.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the

executive departments and agencies of the federal government.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department - The State Department of Social and Health Services. (WAC 388-500-0005)

Diagnosis Related Group (DRG) – A classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria. (WAC 388-550-1050)

Division of Health Services Quality Support (DHSQS) - A division within the Medical Assistance Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service programs.

Division of Program Support (DPS) - The division within the Medical Assistance Administration that processes claims for payment under the Title XIX (Medicaid) federal program and state-funded programs.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

General Assistance - Unemployable (GAU) - GAU is the state-funded program which provides cash and medical benefits to persons with a physical or mental incapacity who are unemployable for more than 90 days. Medical care is limited within Washington State and border areas; out-of-state-care is not allowed.

Level A Services – Hospital-based acute rehabilitation services for medically stable clients with conditions that require complex nursing, medical, and therapy needs as listed in WAC 388-550-2551(2). Such conditions include, but are not limited to, traumatic brain injuries, spinal cord injuries, and complicated bilateral amputations. (WAC 388-550-2511)

Level B Services – Hospital- or nursing facility-based acute rehabilitation services for medically stable clients with new or exacerbated multiple sclerosis, mild head injuries, spinal cord injuries following the removal of the thoracic lumbar sacral orthosis (TLSO), and other medical conditions that require less complex nursing, medical and therapy needs as listed in WAC 388-550-2551(3). (WAC 388-550-2511)

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and

ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider who is responsible for arranging or delivering all contracted medical care. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) – The unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs. (WAC 388-500-0005)

Medical Assistance IDentification (MAID) cards – MAID cards are the forms the Department of Social and Health Services uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medically Indigent (MI) – MI is the state-funded program for persons with an emergency medical condition requiring hospital services who are not eligible for cash benefits or for any other medical program. MI covers only emergency transportation services, hospital, and related physician services in a hospital.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two

parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Noncovered Service or Charge - A service or charge that is not covered by the Medical Assistance Administration, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure. (WAC 388-550-1050)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Per Diem Charge - The daily charge per client that a facility may bill or is allowed to receive as payment for its services.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Ratio of Costs to Charges (RCC) - The methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services. (WAC 388-550-1050)

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) – Laws of the Washington State.

Short-term – Two months or less.

Third Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed:*

1) The usual and customary charge that a

provider bills the general public for the same services, or

2) If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Acute Physical Medicine & Rehabilitation

What is Acute Physical Medicine & Rehabilitation (Acute PM&R)? (Refer to WAC 388-550-2501)

Acute Physical Medicine and Rehabilitation (Acute PM&R) is a 24-hour inpatient comprehensive program of integrated acute medical and rehabilitative services during the acute phase of rehabilitation. Acute PM&R requires prior authorization by the Medical Assistance Administration (MAA). (See "*Is prior authorization required for Acute PM&R services?"*)

A multidisciplinary team at an MAA-approved inpatient rehabilitation facility coordinates individualized Acute PM&R services to achieve the following for the client:

- Improved health and welfare; and
- Maximum physical, social, psychological, and vocational potential.

MAA determines the length of stay based upon community standards of care for Acute PM&R services and individual case reviews. To help the client achieve the maximum rehabilitation potential, additional therapy must be continued through other covered programs such as:

- Home Health Services;
- Nursing Facilities; or
- Outpatient Hospital Services.

MAA's Acute PM&R program is regulated by:

MAA's Acute PM&R program is regulated by:

- RCW 74.09.520, Medical assistance—Care and services included—Funding limitations;
- WAC 388-550-2501 through 388-550-3401, Acute PM&R; and
- The contractual provider agreement.

<u>This program is NOT related to, nor does it qualify any facility for, the Department of Health's (DOH) Acute Trauma Rehabilitation Designation program.</u>

How does a rehabilitation facility become a Level A or B Acute PM&R Provider? **(Refer to WAC 388-550-2531)**

To provide Acute PM&R services to medical assistance clients, a provider obtains MAA approval for the facility. To obtain MAA approval for the facility, the provider must:

- Submit a letter of request;
- Include evidence that confirms the requirements listed in this section are met; and
- Send the letter and documentation to:

  Acute PM&R Program Manager
  Division of Health Services Quality Support
  Medical Assistance Administration
  PO Box 45506
  Olympia, WA 98504-5506

Level A

In order to be approved by MAA as a **Level A** provider, a **hospital** must be all of the following:

- Medicare certified;
- Accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- Licensed by the Department of Health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions);
- CARF accredited for Comprehensive Integrated Inpatient Rehabilitation Programs; and
- **Operating** per the standards set by DOH, excluding the Certified Rehabilitation Registered Nurse (CRRN) requirement, in either:

  - ✓ WAC 246-976-830, Level I Trauma Rehabilitation Designation; or
  - ✓ WAC 246-976-840, Level II Trauma Rehabilitation Designation.

Level B

In order to be approved by and contracted with MAA as a **Level B** provider, a **facility** must be all of the following:

- Medicare certified;
- Licensed by DOH as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions) or nursing facility;
- CARF accredited for Comprehensive Integrated Inpatient Rehabilitation Programs;
- Contracted under MAA's selective contracting program; and
- **Operating** per the standards set by DOH in WAC 246-976-840, Level II Trauma Rehabilitation Designation, excluding the CRRN requirement.

MAA may consent to conditional contract approval when the applying facility meets the criteria in this section, excluding the CARF accreditation requirement listed in this section. The facility must:

- Actively operate under CARF standards; and
- Have begun the process of obtaining full CARF accreditation.

MAA will revoke a conditional contract approval if the facility does not obtain full CARF accreditation within twelve months of the conditional approval date by MAA. MAA will not take back payment for services delivered to MAA clients if conditional contract approval is revoked.

For more information about becoming an MAA-approved Acute PM&R facility, please contact DHSQS Quality Fee-For-Service Program Manager at (360) 586-5305.

☞ **NOTE:** If a facility is working with a CARF consultant, a letter of active intent showing time lines of facility operation under CARF standards must be submitted to MAA at the time of application. Full CARF accreditation must be obtained within 12 months of MAA's approval and maintained for the full term of the contract with MAA.

Is prior authorization required for Acute PM&R services?
(WAC 388-550-2501)

YES! **<u>All</u> inpatient acute physical medicine and rehabilitation services <u>require prior authorization</u>.**

What are the requirements for authorization? (WAC 388-550-2561)

1. The patient care coordinator or the attending physician must call the MAA clinical consultation team before admitting an MAA client.

2. The patient care coordinator or attending physician must provide to MAA objective information showing that:

   - Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care, independence, or both;

   - The client's medical condition requires that intensive 24-hour inpatient comprehensive Acute PM&R services be provided in an MAA-approved Acute PM&R facility; and

   - The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits.

3. Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and capable to participate at least three hours per day, seven days per week, in Acute PM&R activities.

4. For extension of authorization, the facility's rehabilitation staff must provide adequate medical justification, including significant observable improvement in the client's condition, to MAA prior to the expiration of the initial approved stay. If MAA denies the extension, the client must be transferred to an appropriate lower level of care as defined in WAC 388-550-2501 (3).

☞ **NOTE:** The following require prior authorization:

- All extensions to services; and
- Administrative days.

5. MAA may authorize administrative day reimbursement for clients who do not meet requirements described in this section, or who stay in the facility longer than the community standard's length of stay. The administrative day rate is the statewide Medicaid average daily nursing facility rate as determined by the department.

☞ **NOTE:** Authorization will be considered on a case-by-case basis after eligibility is established.

TO RECEIVE PRIOR AUTHORIZATION
Call:
DHSQS Clinical Consultation Team
1-800-634-1398

How does MAA determine client placement in Level A or B Acute PM&R? [WAC 388-550-2551(1)]

At the time of authorization, MAA determines the most appropriate client placement on a case-by-case basis:

- In the level of care (Level A or B);
- In the least restrictive environment; and
- At the lowest cost to MAA.

Individualized Acute PM&R services may be authorized when a client has the ability to regain and restore normal or near normal function following acute disease, illness, or injury.

Significant and observable improvement in the client's condition must take place during the authorized Acute PM&R treatment periods, or MAA will deny extensions for authorization and the client will be transferred to an appropriate lower level of care. [Refer to WAC 388-550-2561(4)]

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible? [Refer to WAC 388-550-2521 (1)]

Clients presenting Medical Assistance IDentification (MAID) cards with the following program identifiers **are eligible** for Acute PM&R - **Level A and Level B** services:

- **Children's Health**
- **CNP** (Categorically Needy Program)
  (General Assistance – Disability Determination Pending [GA-X] clients are eligible for Acute PM&R services and will be identified by the CNP identifier on their MAID cards.)
- **CNP-QMB** (CNP-Qualified Medicare Beneficiary)
- **LCP-MNP** (Limited Casualty Program - Medically Needy Program)
- **MNP-QMB** (MNP-Qualified Medicare Beneficiary)

Limited Coverage [Refer to WAC 388-550-2521 (2)]

Clients presenting MAID cards with the following program identifiers are eligible for **only Level A hospital-based services:**

- **CNP-Emergency Medical Only**
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **Emergency Hospital And Ambulance Only** (Medically Indigent Program)

> **…Emergency hospital-based and emergency transportation services.** These clients may only receive services when they are transferred directly from an acute hospital stay and the Acute PM&R needs are directly related to the medical need for the hospital stay.

- **GA-U No Out Of State Care** (General Assistance-Unemployable) - Any Acute PM&R services performed out-of-state, except for border areas, are not covered.
- **MNP-Emergency Medical Only…**

Who is not eligible? [Refer to WAC 388-550-2521 (3)]

MAA will not reimburse providers for services provided to clients with the following identifier on their MAID cards:

- **Family Planning Only**

Are clients enrolled in managed care eligible?
[Refer to WAC 388-550-2521 (4)]

Acute PM&R services are covered under the MAA managed care program (Healthy Options). Clients enrolled in a managed care plan will have an HMO indicator in the HMO column on their MAID card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 1-800 telephone number is located on the client's MAID card. MAA does not process or reimburse claims for managed care (Healthy Options) clients for services provided under the Healthy Options contract.

To prevent claim denials, please check the client's MAID card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the plan.

Primary Care Case Management (PCCM) clients will have the identifier **PCCM** in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required on the HCFA-1500 claim form. (See *Billing* for further information.)

Level A Hospital-Based Acute PM&R

How does a client qualify for Level A services?

Authorization for Acute PM&R within a hospital based Level A acute rehabilitation setting is based on clients who have **extensive or complex:**

medical needs	- and -	**nursing needs**	- and -	**therapy needs.**

Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and able to participate at least three (3) hours per day, seven (7) days per week in Acute PM&R activities. They must show an impairment in two or more of the following areas:

- Mobility and strength;
- Self-care/ADLs (Activities of Daily Living);
- Communication;
- Continence-evacuation of bladder and/or bowel;
- Kitchen/food preparation-safety and skill;
- Cognitive/perceptual functioning; or
- Pathfinding skills and safety.

Examples of Level A conditions: [Refer to WAC 388-550-2551 (2)]

Clients with new or recent onset of conditions including, but not limited to, the examples listed below are usually appropriate for placement in a Level A hospital-based acute rehabilitation:

1. Severe head injury with cognitive and/or motor deficits;
2. Craniotomy for brain tumor with cognitive/motor deficits who need close monitoring for follow-up radiation or surgery and easy availability to the same;
3. Cognitive/motor deficits caused by toxic effects of poisons (e.g. botulism) or from an overdose of drugs or alcohol that caused an anoxic event with ensuing brain damage;
4. Brain damage from infectious brain diseases such as encephalitis;
5. Spinal cord injuries (e.g. quadriplegia or paraplegia);
6. Skin flap grafts for decubitus ulcers that need to be closely observed by the surgeon, and the client is ready to mobilize or to be up in a chair;
7. Extensive burns that require complex medical care and debridement;
8. Bilateral limb loss that needs close observation, and the client has complex medical needs;
9. Multiple trauma with complicated orthopedic conditions with neurological deficits (e.g., fracture of pelvis and a co-existing head injury); **or**
10. Cerebral vascular accident with resulting hemiplegia or severe cognitive deficits with speech and swallowing deficits that needs close intervention with radiological evaluation and/or other complex medical needs.

Required medical needs for Level A services:

1. Twenty-four hour availability of a physiatrist to:

    a) Monitor, direct, and coordinate the multidisciplinary rehabilitation plan; **or**
    b) Assess for complications, such as venous thrombosis, infections, cardiovascular or respiratory compromise.

2. On-site (24 hour availability) medical or surgical consultants in specialty areas including, but not limited to:

    a) Orthopedics for extensive or unstable fractures;
    b) Neurosurgery for potentially unstable intracranial lesions;
    c) Neurology for continued diagnostic work-up or neurologic instability;
    d) Internal medicine for new, or changing medical problems requiring frequent monitoring and/or intervention;
    e) Pain/anesthesiology for poorly controlled pain issues;
    f) General surgery for potentially unstable intra-abdominal lesions; **or**
    g) Psychology or psychiatry for unstable medical conditions and psychological testing.

3. On-site (24 hour availability) laboratory, radiology, or pharmacy facilities for issues

including, but not limited to:

a) Monitoring new or unstable anticoagulation;
b) History of, and probable need for, frequent or emergent CT, MRI, or nuclear medicine evaluations, radiographic evaluation, or monitoring of dysphagia, or other complex/unusual radiologic procedures;
c) Likely status changes in medical or titrated medications such as IV heparin, or multiple IV antibiotics; **or**
d) Unstable or potentially unstable diabetes, congestive heart failure, or immunosuppression.

4. On-site (24 hour availability) respiratory therapy with multiple treatments each day for unstable or evolving pulmonary condition.

Examples of complex nursing needs for Level A services:

1. New onset neurogenic bladder with new spinal cord injury (without established management program);
2. Following a new deep venous thrombosis (DVT) while remaining at risk of developing another DVT but able to participate in a full rehabilitation program;
3. New onset seizures or high risk for new onset seizures;
4. Autonomic hyperreflexia associated with multiple complex needs from a new spinal cord injury;
5. Wounds that need plastic surgery follow-up on a daily or nearly daily basis;
6. Burns with significant open wounds or scarring;
7. Frequent (more than twice daily) blood draws;
8. Requirements for more than two drug levels per day; **and/or**
9. New ventilator/tracheostomy.

Examples of therapy needs for Level A services:

1. Neurobehavioral complications requiring psychological intervention with the client, family, and team, including, but not limited to:

a) Agitation - which does not limit ability to participate in a rehabilitation program;
b) Noncompliance;
c) Major depression;
d) Post-traumatic stress disorder; **or**
e) Other neurobehavioral complications that may require psychological intervention with the client, family, and team.

2. Neuropsychological needs that require daily contact with a licensed psychiatrist for:

a) Assessment/program development;
b) Continued monitoring and adjustment of program; **or**
c) Work with family, such as unawareness of deficits or multiple areas of cognitive or language impairment (e.g. multi-focal traumatic brain injury or impairment in attention, memory and language simultaneously).

3. Co-existing alcohol or drug problems that have not been addressed, or do not have an established intervention program.

4. Tracheostomy that requires frequent or multi-disciplinary or multiple medical intervention.

5. Dysphagia under evaluation, or where status changes and requires repeated radiologic assessments.

6. Communication impairments that require advanced technological interventions.

7. Complex or extensive bracing needs with associated medical risks or complications.

8. Complex splinting issues, or for poorly controlled spasticity requiring orthopedic or hand surgeons.

9. Occupational therapy needs that require more advanced technological support.

10. Need for multiple therapy disciplines with Physical Therapy (PT), Occupational Therapy (OT), Therapeutic Recreation (TR), Psychiatry/Psychology (Psych.), Speech Therapy (ST), and/or extensive nursing education, every day.

11. Specialized seating problems that require a high level of technological support or adaptation, or assistive support with a multi-disciplinary approach.

What is included in the Level A room and board?
(WAC 388-550-3381 (2)]

Level A inpatient Acute PM&R **room and board** includes, but is not limited to:

- Facility use;
- Medical social services;
- Bed and standard room furnishings; and
- Nursing services.

How is reimbursement determined for Level A services?

MAA will reimburse an approved Level A Acute PM&R facility for authorized medically necessary inpatient Acute PM&R services at the individual hospital's ratio of costs to charges (RCC) rate. **Do not bill separately for:**

- Transportation services that are provided after admission, but prior to discharge, except for those services excluded from the contract and provided at a different facility.

- Services provided by the provider within 24 hours prior to the client's admission as an inpatient (such as outpatient or emergency services, that are related to the condition for which the client is admitted as an inpatient). These services are deemed inpatient services and included in the daily rate.

- Drugs, biologicals, supplies, appliances, and equipment furnished by the **hospital** to the client that are related to the condition for which the client is admitted as an inpatient and considered part of regular accommodations under Title XIX of the Social Security Act.

MAA's payment obligation consists of the allowed charges multiplied by the RCC **minus** the sum of:

- Client liability (whether or not collected by the contracted provider) and
- Other coverage from third parties, collected or collectible (if timely claimed by the contracted provider), including, but not limited to:
  - ✓ Insurers and indemnitors;
  - ✓ Other federal or state medical care programs;
  - ✓ Payments actually made to the provider on behalf of the client, whether before or after the services are provided by individuals or organizations (other than insurers or Federal/State programs) not legally liable for the client's financial obligations; **and**
  - ✓ Any other contractual or legal entitlement of the client, including, but not limited to: workers' compensation, crime victims' compensation, individual or group insurance, court-ordered dependent support arrangements, and the tort liability of any third party.

☞ **NOTE:** For third party liability cases, MAA's payment obligation is the lesser of either the contractual payment amount or the contractor's billed and allowed charges, minus the sum of client liability and other third parties as listed above.

Level B Nursing Facility or Hospital-Based Acute PM&R

What services are included in the Level B per diem rate for nursing facilities?

Services listed in 1 through 5 below are related to a client's rehab diagnosis and are included in the per diem rate. The Level B Inpatient Acute PM&R per diem rate for **room and board** includes, but is not limited to, the following services:

1. Medical, nursing, surgical, dietary services and non-prescription drugs and supplies. Refer to WAC 388-97-135, **Pharmacy Services** [for Nursing Facilities];

2. All diagnostic and therapeutic services required by the client;

3. The technical and professional components of services:

    a) Audiology/speech pathology;
    b) Inhalation/respiratory therapy;
    c) Occupational therapy; and
    d) Physical therapy;

4. **The technical component only of laboratory and radiology services;** and

5. Use of facilities, medical social services furnished by the provider, and such prescription/pharmaceuticals related to the rehabilitation diagnosis, appliances, and equipment.

What services are excluded from the Level B per diem rate for nursing facilities

Equipment and services excluded from the nursing facility per diem rate are usually billed to MAA by different providers. The *provider of the service* may bill MAA using the applicable fee schedules as published by DSHS.

The equipment and services listed below are not included in the per diem rate and may be billed separately. They include, but are not limited to:

Angiography
Blood products
Chemotherapy
Customized adaptive appliances
Dialysis
Epogen/neupogen
Gastroenterology/surgical procedures
IV infusion therapy
MRI/CAT scans
Outpatient diagnostic tests
Personal specialized, wheelchair, ventilator, or orthotics *for home use*
Professional services (not included in #3 on previous page), billed through RBRVS fee schedule)
Prescription pharmaceuticals
Psychological evaluations
Specialty beds while in a Level B Acute PM&R nursing facility
Radiation therapy
TPN (Total Parenteral Nutrition)

What services are included in the Level B per diem rate for inpatient hospitals

Services listed below are related to a client's rehab diagnosis and included in the per diem rate. The Level B Inpatient Acute PM&R per diem rate for room and board includes, but is not limited to, the following services:

1. Medical, nursing, surgical, dietary services, and non-prescription drugs and supplies;

2. Diagnostic and therapeutic services required by the client;

3. The technical and professional components of services:

    a) Audiology/speech pathology;
    b) Inhalation/respiratory therapy;
    c) Occupational therapy; and
    d) Physical therapy.

4. **The technical component only of laboratory and radiology services**; and

5. Use of facilities, medical social services furnished by the provider, and prescriptions and/or pharmaceuticals related to the rehabilitation diagnosis, appliances, and equipment.

What services are provided by the hospital that may be billed outside the Level B per diem rate

Services and equipment outside of the daily per diem rate may be reimbursed under the:

- Outpatient Hospital Billing Instructions and fee schedule;
- Resource Based Relative Value Scale (RBRVS); or
- Other applicable fee schedules as published by the Department of Social and Health Services.

The equipment and services listed below are not included in the per diem rate and may be billed separately. They include, but are not limited to:

Angiography
Blood products
Chemotherapy
Customized adaptive appliances
Dialysis
Epogen/neupogen
Gastroenterology/surgical procedures
IV infusion therapy
MRI/CAT scans
Outpatient diagnostic tests
Personal specialized, wheelchair, ventilator, or orthotics *for home use*
Professional services (not included in #3 on previous page), billed through RBRVS fee schedule)
Prescription pharmaceuticals
Psychological evaluations
Specialty beds while in a Level B Acute PM&R nursing facility
Radiation therapy
TPN (Total Parenteral Nutrition)

How does a client qualify for Level B services?

Authorization for Acute PM&R with a nursing facility or hospital based Level B acute rehabilitation setting is based on clients who have extensive or complex:

medical needs	- and -	**nursing needs**	- and -	**therapy needs.**

Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and able to participate at least three (3) hours per day, seven (7) days per week in Acute PM&R activities. They must show an impairment in two or more of the following areas:

- Mobility and strength;
- Self-care/ADLs (Activities of Daily Living);
- Communication;
- Continence-evacuation of bladder and/or bowel;
- Kitchen/food preparation-safety and skill;
- Cognitive/perceptual functioning; or
- Pathfinding skills and safety.

Examples of Level B Conditions: [Refer to WAC 388-550-2551(3)]

Clients with new or recent onset of conditions including, but not limited to, the examples listed below are usually appropriate for placement in a Level B inpatient acute rehabilitation facility:

- New strokes when medically stable;
- Newly diagnosed or recently exacerbated multiple sclerosis with additional loss of function;
- New mild head-injuries when medically stable; **or**
- Spinal cord injuries following the removal of a Thoracic Lumbar Sacral Orthosis (TLSO), which may have included Intermittent Catheter Placement (ICP) and bowel training, after the client's first phase of acute rehabilitation.

Required medical needs for Level B services:

1. To be seen by a physiatrist at least four times per week;
2. To have available, an on-call medical consultant;
3. To have the availability of respiratory therapy; **and**
4. To have available an on-call laboratory, radiology, or pharmacy facilities.

Examples of nursing needs for Level B services:

1. Respiratory therapy and suctioning;
2. Ventilator support;
3. New onset neurogenic bladder and/or bowel programs (facility must meet MAA's criteria established for providing these services);
4. Established swallowing programs; **and/or**
5. Tube feedings.

Examples of therapy needs for Level B services:

1. Neuropsychological complications not requiring daily psychological intervention;
2. Co-existing alcohol or drug problems when an established intervention program is already in place;
3. Tracheostomy which is established and may require nursing and speech intervention;
4. Dysphagia without frequent radiologic needs;
5. Bracing needs without associated medical needs, or complications;
6. Spasticity which does not require invasive interventions; **and/or**
7. Specialized seating problems that do not require a high level of technological support or adaptation, or assistive support with a multi-disciplinary approach.

Hospitals may be reimbursed for administrative days for clients who do not meet this criteria or whose length of stay exceeds the community standards. These administrative days are based on the statewide Medicaid average daily nursing facility rate as determined by DSHS.

How is reimbursement determined for Level B services?

[WAC 388-550-3401 (1)(2)(3)]

MAA pays a contracted Level B facility for Acute PM&R services at a fixed daily rate established by MAA.

MAA may make cost inflation adjustments to the maximum daily rate by using the same inflation factor and schedule that MAA uses to pay independent hospitals. This diagnosis-related group (DRG) reimbursement method is described in WAC 388-550-3450(5)(a).

MAA pays the rate in effect at the time of a client's admission to a facility.

Do not bill separately for:

- Transportation services that are provided after admission, but prior to discharge, except for those services excluded from the contract and that are provided at a different facility.

- Services provided within 24 hours prior to the client's admission as an inpatient (such as outpatient or emergency services, that are related to the condition for which the client is admitted as an inpatient). These services will be deemed inpatient services and are included in the daily rate.

- Drugs, biological, supplies, appliances, and equipment furnished by the **nursing facility** under Title XIX of the Social Security Act. [WAC 388-97-135 **Nursing Homes Pharmacy Services** further clarifies what is included in the regular accommodation of nursing services.]

DSHS's payment obligation consists of the amount that DSHS would have been liable to pay to the provider **minus** the sum of:

- Client liability (whether or not collected by the contractor provider) and

- Other coverage from third parties, collected or collectible (if timely claimed by the contractor provider), including, but not limited to:

  - ✓ Insurers and indemnitors;

  - ✓ Other federal or state medical care programs;

  - ✓ Payments actually made to the provider on behalf of the client, whether before or after the services are provided by individuals or organizations (other than insurers or Federal/State programs) not legally liable for the client's financial obligations; **and**

  - ✓ Any other contractual or legal entitlement of the client, including, but not limited to, workers' compensation, crime victims' compensation, individual or group insurance, court-ordered dependent support arrangements, and the tort liability of any third party.

☞ **NOTE:** For third party liability cases, DSHS's payment obligation is the lesser of either the contractual payment amount or the contractor's billed and allowed charges, minus the sum of client liability and other third parties as listed above.

Covered Revenue Codes and Condition Codes

Covered Revenue Codes

Level A

Any applicable revenue code may be used when billing MAA for Level **A** Acute PM&R services.

Level B

You may only use the following revenue codes when billing MAA for Level **B** Acute PM&R services:

DESCRIPTION	REVENUE CODE
Room/Board – Rehabilitation daily (per diem) rate	128
Administrative Days for Hospitals only (Clients no longer meeting Acute PM&R status - *upon approval, the state of Washington will pay statewide average nursing home rate)*	169
Prescription pharmaceuticals/drugs *(Allowable for hospital-based facilities only.)*	250

Condition Codes (entered in Box 24)

DESCRIPTION	CONDITION CODE
Level A	R1
Level B	R2

Billing

What is the time limit for billing?

State law requires that you present your final charges to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **MAA will not pay if:**

  - ✓ The service or product is not covered by MAA;
  - ✓ The service or product is not medically necessary;
  - ✓ The client has third party coverage, and the third party pays as much as, or more than MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Assistance IDentification (MAID) card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the Primary Care Case Manager(s) (PCCM) who referred the client for the services(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

What must I keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide.

- **Chart** means a summary of medical records on an individual patient.
- **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be in chronological order by the practitioner who provided the service.

For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to the Department of Social and Health Services (DSHS) or its contractor and to the U.S. Department of Health and Human Services upon request.

Quality of care for Acute PM&R clients through audits and reviews

(WAC 388-550-2541)

To ensure quality of care, MAA may conduct an on-site review of any MAA-approved Acute PM&R facility. See WAC 388-501-0130, Administrative controls, for additional information on audits conducted by department staff. In addition, MAA approved Level B nursing facilities are subject to regular on-site surveys conducted by the department's Aging and Adult Services Administration (AASA).

[Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's medical assistance ID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
20 = Expired
30 = Still patient

24 **Condition Code** -

R1 = Level A

R2 = Level B

32-35. **Occurrence Codes and Dates** - Beginning in form locator 32, enter one or more of the following codes, if applicable.

J0 = Baby on mom's PIC
01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
06 = Crime Victims
X1 = Trauma Condition Code

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

57. **Due From Patient - Spenddown**

58. **Insured's Name: A/B/C** - If other

insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis**

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample A: Level A Services UB-92 Claim Form

Sample B: Level B Services UB-92 Claim Form

How to Complete the UB-92 Medicare Part B/Medicaid Crossover Claim Form

(Use these instructions when submitting claims for dual-eligible [Medicare/Medicaid] clients.)

You must submit the Medicare/Medicaid billing form UB-92 to:

Division of Program Support
PO Box 9246
Olympia WA 98507-9246

along with a copy of your Explanation of Medicare Benefits (EOMB).

The numbered boxes on the claim form are referred to as ***form locators***. *Only form locators that pertain to MAA are addressed here.*

Complete the UB-92 claim form in the usual manner required by MAA; however, there are form locators that need specific information indicated in order to process your claim. See the following instructions and claim form samples.

FORM LOCATOR, NAME AND INSTRUCTION FOR COMPLETION

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Services (DPS).

3. **Patient Control No**. - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 - Hospital

Bill Classification (second digit)
1 (Inpatient)

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's MAID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the next column.

CODE	TIME: A.M.	CODE	TIME: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
20 = Expired
30 = Still patient

24 **Condition Code** -

R1 = Level A
R2 = Level B

32-35. **Occurrence Codes And Dates** - Beginning in form locator 32, enter one or more of the following codes, if applicable.

J0 = Baby on mom's PIC
01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
06 = Crime Victims
X1 = Trauma Condition Code

39-41. **Value Codes and Amounts**

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or

procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the provider number issued to you by the payor.

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

57. **Due From Patient - Spenddown**

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID No.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If

other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis**

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, the referring PCCM provider number must be used.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample A: Level A Services Medicare Part B/Medicaid Crossover UB-92 Claim Form

Sample B: Level B Services Medicare Part B/Medicaid Crossover UB-92 Claim Form

This is a blank page…